Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MCALLEN MEDICAL CENTER
3255 W PIONEER PKWY
PANTEGO TX 76013-4620

Respondent Name
AMERICAN HOME ASSURANCE COMPANY

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-08-3390-01

MFDR Date Received
January 23, 2008

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Knowing that TWCC is hoping to move to a %-over-Medicare allowance for hospital claims, we have reviewed the Medicare DRG allowance and decided your reimbursement does not meet our own determination of fair and reasonable. . . . Medicare would have allowed the provider 140% of the allowable which would be $5,574.25."

Amount in Dispute: $3,440.20

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We believe our reimbursement represents a fair and reasonable payment for these services."

Response Submitted by: AIG Insurance Services, Inc. 8144 Walnut Hill Lane, Suite 1500, Dallas, Texas 75231

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
February 6, 2007 to February 7, 2007	Outpatient Hospital Services	$3,440.20	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 sets forth general provisions related to medical reimbursement.
3. 28 Texas Administrative Code §134.401 sets out the fee guideline for acute care inpatient hospital services.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.

5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 18 – Duplicate claim/service.
   - 150 – Payment adjusted because the payer deems the information submitted does not support this level of service.
   - 24 – Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.
   - 42 – Charges exceed our fee schedule or maximum allowable amount.
   - 8 – Procedures billed are outside of the scope of the providers specialty.
   - W1 – Workers Compensation State Fee Schedule Adjustment

Findings

1. The insurance carrier reduced payment for disputed services with reason codes 24 – "Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan" and 42 – "Charges exceed our fee schedule or maximum allowable amount." Review of the submitted information found no documentation to support that the disputed services are subject to a contractual fee arrangement, managed care plan or capitation agreement between the parties to this dispute. Nevertheless, on November 9, 2010, the Division requested the respondent to provide a copy of the referenced contract between the alleged network and the requestor, pursuant to former 28 Texas Administrative Code §133.307(e)(1), effective December 31, 2006, 31Texas Register 10314, which states that "The Division may request additional information from either party to review the medical fee issues in dispute. The additional information must be received by the Division no later than 14 days after receipt of this request. If the Division does not receive the requested additional information within 14 days after receipt of the request, then the Division may base its decision on the information available." While the respondent did submit a copy of a contract for review, the submitted contract does not reference the name of the health care provider, does not reference the service location, or even the correct city in which the hospital is located. Further, no documentation was found to support that the insurance carrier, American Home Assurance Company, was participating in or eligible to access a contractual fee arrangement with the alleged network. The Division therefore concludes that the disputed services are not subject to a contract between the parties to this dispute. The above payment reduction reasons are not supported. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. 28 Texas Administrative Code §134.401(b)(1)(B), effective August 1, 1997, 22 *Texas Register* 6264, defines inpatient services as "Health care, as defined by the Texas Labor Code, §401.011(19), provided by an acute care hospital and rendered to a person who is admitted to an acute care hospital and whose length of stay exceeds 23 hours in any unit of the acute care hospital." Review of box 17 and 18 on the requestor's medical bill finds that the injured worker was admitted on February 6, 2007 at hour 21. Review of box 6 and box 21 finds that the injured worker was discharged on February 6, 2007 at hour 10. The submitted documentation supports that the length of stay did not exceeded 23 hours; the Division therefore concludes that the services in dispute are outpatient services.
3. This dispute relates to services with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.1, effective May 2, 2006, 31 *Texas Register* 3561, which requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
5. Former 28 Texas Administrative Code §133.307(c)(2)(F)(iii), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include a position statement of the disputed issues including "how the Labor Code, Division rules, and fee guidelines impact the disputed fee issues." Review of the submitted documentation finds that the requestor has not discussed how the Labor Code, Division rules and fee guidelines impact the disputed fee issues. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(F)(iii).
6. Former 28 Texas Administrative Code §133.307(c)(2)(F)(iv), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include a position statement of the disputed issues including "how the submitted documentation supports the requestor position for each disputed fee issue." Review of the submitted documentation finds that the requestor has not discussed how the submitted documentation supports the requestor position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(F)(iv).

7. Former 28 Texas Administrative Code §133.307(c)(2)(G), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:
   - The requestor's position statement asserts that "Knowing that TWCC is hoping to move to a %-over-Medicare allowance for hospital claims, we have reviewed the Medicare DRG allowance and decided your reimbursement does not meet our own determination of fair and reasonable. . . . Medicare would have allowed the provider 140% of the allowable which would be $5,574.25."
   - The requestor did not submit documentation to support that Medicare would have allowed the provider 140% of the allowable.
   - The requestor does not explain or discuss why Medicare's reimbursement formula for inpatient services should be applicable to the outpatient services in dispute.
   - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
   - The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

   The request for additional reimbursement is not supported. Thorough review of the submitted documentation finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	December 3, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.